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ABSTRACT

Mentally retarded individuals may have chronic emotional problems or emotional responses to such stress and conflict situations as attending separate classes, moving to a new living situation, or being separated from family. Frequently service networks for mentally retarded persons do not consider the need for emotional assistance, as demonstrated by a survey administered to 51 service providers in mental retardation and mental health settings in which 78 percent of the respondents indicated discomfort in working with the emotional needs of the mentally retarded. Respondents preferred a pychotherapeutic approach (58%) to behavior modification (36%), and judged the two orientations as mutually exclusive. Findings suggested the need for desensitization to precede training programs for professionals so that they will be comfortable with people who have mental retardation. (CL)

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LINKING RESIDENTIAL AND VOCATIONAL SERVICES TO ENHANCE CLIENT PROGRAMMING

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THE BASIS OF A GOOD SERVICE NETWORK ARE ALL FAMILIAR TO US:

.. ESTABLISHING CONTACT PEOPLE IN EACH AGENCY

.. ESTABLISHING A SYSTEM OF COMMUNICATION BETWEEN THOSE CONTACT PEOPLE

.. DEVELOPING COMMON PROGRAMS

.. JOINT PROBLEM SOLVING

IF THESE PIECES ARE PRESENT, WE CAN OFTEN HAVE A GOOD SERVICE NETWORK REGARDLESS OF HOW THESE PIECES FIT INTO THE OVERALL SYSTEM. THESE PIECES CAN BE PACKAGED IN A VARIETY OF WAYS AND THE SYSTEM CAN FUNCTION EFFECTIVELY. THE CLIENT GETS GOOD RESIDENTIAL PROGRAMS, GOOD VOCATIONAL PROGRAMS AND GOOD RECREATIONAL PROGRAMS IN A COORDINATED AND SMOOTH RUNNING SYSTEM.

WHAT HAPPENS IF THE SYSTEM IS WORKING EFFECTIVELY AND STILL SOME CLIENTS DO NOT PROGRESS? THE WORKSHOP OR VOCATIONAL SITE AND THE RESIDENTIAL PROGRAM ATTEMPT TO ALTER THEIR APPROACHES TO ENABLE THE CLIENT TO MOVE AHEAD. FREQUENTLY, THIS IS OF BENEFIT TO THE CLIENT, BUT THERE ARE THOSE PEOPLE WHO CONTINUE TO DO POORLY. THEY MAY EITHER ACTIVELY REFUSE TO PARTICIPATE IN THE PROGRAM OR THEY MAY BE MORE PASSIVE AND WITHDRAWN. THIS IS NOT AN UNUSUAL INCIDENT IN EITHER A RESIDENTIAL OR VOCATIONAL SETTING.

THESE PEOPLE ARE FREQUENTLY THOSE WHO ALSO HAVE EMOTIONAL DIFFICULTIES. IN FACT, THE PREVILANCE OF EMOTIONAL DISTURBANCE AMONG THE MENTALLY RETARDED IS SIGNIFICANTLY GREATER THAN THAT IN THE GENERAL PUBLIC, FORTY TO SIXTY PER CENT (40-60%) OF THE MENTALLY RETARDED ALSO HAVE A PSYCHOPATHOLOGICAL CONDITION. WE HAVE COME A LONG WAY IN ACKNOWLEDGING THAT THE MENTALLY RETARDED CAN AND DO HAVE EMOTIONAL PROBLEMS. WE ARE ALSO BEGINNING TO ACKNOWLEDGE THE FACT THAT THESE EMOTIONAL PROBLEMS CAN GO BEYOND "ACTING OUT" BEHAVIORS. IN FACT, A LARGE NUMBER OF EMOTIONALLY DISTURBED AND MENTALLY RETARDED INDIVIDUALS FANTASIZE, WITHDRAW, ARE DELUSIONAL OR ARE ANXIOUS AND DO NOT AGGRESS. AS WAS STATED PREVIOUSLY, WE ARE BEGINNING TO ACKNOWLEDGE THAT

THESE CONDITIONS EXIST AMONG THE MENTALLY RETARDED, BUT UNFORTUNATELY, WE ARE LAGGING BEHIND WITH REGARD TO APPROPRIATE INTERVENTIONS.

THERE ARE OTHER MENTALLY RETARDED PEOPLE IN OUR VOCATIONAL AND RESIDENTIAL PROGRAMS WHO MAY BE EXPERIENCING SITUATIONAL PROBLEMS THAT MAY INTERFERE WITH THEIR GOAL PLANS. A PERSON MAY BE MOVING INTO A NEW APARTMENT, AND MAY BE EXPERIENCING SOME DEGREE OF STRESS AS A RESULT. A LOVED ONE MAY DIE, AND THE INDIVIDUAL GOES THROUGH A GRIEF PROCESS. MOVING TO A NEW HOME AND THE DEATH OF A LOVED ONE ARE EXTREME STRESSORS TO THE REST OF US. I THINK WE SHOULD ASSUME THAT THEY ARE STRESSORS TO OUR MENTALLY RETARDED CLIENTS AS WELL.

IN ADDITION TO THE SITUATIONAL STRESS, MANY MENTALLY RETARDED INDIVIDUALS, MANY OF WHOM ARE WITHOUT EXTREME EMOTIONAL PROBLEMS, EXPERIENCE A GREAT DEAL OF STRESS IN THEIR EVERYDAY LIVES. THERE ARE MANY FACTORS INHERENT IN THE LABEL OF "MENTAL RETARDATION" WHICH GENERATE CONFLICTS IN THESE PEOPLE'S LIVES:

- - GOING TO SEPARATE "SPECIAL" CLASSES IN SCHOOL.
- - NOT BEING INVOLVED SOCIALLY WITH THE REST OF THE CLASS IN HIGH SCHOOL.
- - NOT BEING ABLE TO PARTICIPATE IN ATHLETICS.
- - NOT BEING ABLE TO DRIVE A CAR.
- - HAVING TROUBLE FINDING A BOYFRIEND OR GIRLFRIEND.
- - HAVING VERY STRICT LIMITS PLACED ON WHAT ONE CAN DO SEXUALLY BECAUSE ONE LIVES IN A SHELTERED LIVING ARRANGMENT.
- - BEING SEPARATED FROM FAMILY (FOR THOSE THAT LIVE IN COMMUNITY RESIDENCES).
- - HAVING TO GO TO A SHELTERED WORKSHOP OR VOCATIONAL TRAINING CENTER RATHER THAN DIRECTLY INTO THE WORK FORCE.

BASICALLY, WE ARE TALKING ABOUT ANY SITUATION IN WHICH A MENTALLY RETARDED PERSON CAN NEGATIVELY COMPARE HIM/HERSELF TO A NON-RETARDED PEER AS A POSSIBLE STRESS OR CONFLICT PRODUCING SITUATION. ANY TIME THAT THE PERSON IS CONFRONTED WITH THE FACT THAT THEY ARE MENTALLY RETARDED CAN PRODUCE STRESS.

IN ADDITION, THERE ARE STRESSES, CONFLICTS AND CHANGES IN ONE'S SELF PERCEPTION INHERENT IN THE HABILITATION PROCESS ITSELF. AS ONE LEARNS NEW SKILLS, IS EXPECTED TO MAKE ADDITIONAL DECISIONS FOR ONESELF, IS EXPECTED TO PLAN OR AT LEAST THINK ABOUT THE FUTURE, WE CAN EXPECT INCREASED ANXIETY, MOMENTS OF SELF DOUBT AND PERHAPS AN OUTRIGHT SABOTAGING OF THE PROGRAM.

HOW DO WE ASSIST THE PERSON WHO IS MENTALLY RETARDED AND ALSO EXPERIENCING EMOTIONAL DISTRESS?

HOW DO WE HELP THE PERSON WHO IS GOING THROUGH AN ADJUSTMENT DIFFICULTY?

WHAT DO WE DO WITH THE PERSON WHO IS ANXIOUS AND FULL OF SELF DOUBT AS HE OR SHE ENTERS A NEW PHASE OF THEIR LIFE?

WHAT CAN BE DONE TO ASSIST PEOPLE IN ACCEPTING THE LIMITATIONS OF THEIR RETARDATION AND PROMOTING THEIR SELF WORTH AS HUMAN BEINGS?

THESE ARE THE FACTORS THAT OUR SERVICE NETWORK FREQUENTLY IS NOT TUNED INTO. WE MAY TALK ABOUT AN INDIVIDUAL BEING UNMOTIVATED, BUT WE OFTEN DON'T EXPLORE POSSIBLE EXPLANATIONS. WE MAY TALK ABOUT AN INDIVIDUAL BEING DOWN OR BLUE, AND TRY TO CHEER HIM UP, BUT WE FREQUENTLY DON'T ASSIST HIM IN WORKING THROUGH THE DEPRESSION. WORKERS IN THE FIELD OF MENTAL RETARDATION ARE FREQUENTLY FRIGHTENED BY THE PROSPECT OF HAVING TO DEAL WITH AN EMOTIONAL PROBLEM. WE LOOK OUTSIDE OUR AGENCIES TO THE MENTAL HEALTH CENTERS FOR ASSISTANCE. THE CLIENT IS EXTREMELY FORTUNATE IF HE GETS SEEN IN THE MENTAL HEALTH CENTER, LET ALONE RECEIVE ANY THERAPEUTIC INTERVENTION. THE MENTAL HEALTH WORKERS APPEAR TO BE EXTREMELY RELUCTANT TO SEE MENTALLY RETARDED INDIVIDUALS FOR THERAPY.

THIS IS THE LINK IN OUR SERVICE NETWORK THAT IS VERY FAULTY. MENTAL HEALTH WORKERS RARELY RECEIVE ANY TRAINING IN WORKING WITH MENTALLY RETARDED INDIVIDUALS. WORKERS IN THE FIELD OF MENTAL RETARDATION GENERALLY DO NOT HAVE TRAINING IN PSYCHOTHERAPY OR COUNSELING. AS A RESULT, THE EMOTIONAL NEEDS OF THE MENTALLY RETARDED ARE USUALLY NOT ADDRESSED.

WHAT DO WE DO ABOUT THIS SHORTCOMING? ADMINISTRATIVELY, WE MAY BE ABLE TO INCLUDE PSYCHOTHERAPISTS AND COUNSELORS INTO OUR SERVICE NETWORKS. WE MUST ALSO LOOK HOWEVER AT THESE SERVICE PROVIDERS' PERCEPTIONS OF WORKING WITH THE EMOTIONAL NEEDS OF THE MENTALLY RETARDED.

IN A RECENT STUDY WHICH WAS CONDUCTED BY MICHAEL PLACONA AND MYSELF, WE DID JUST THAT. FIFTY-ONE (51) SERVICE PROVIDERS IN BOTH MENTAL RETARDATION AND MENTAL HEALTH SETTINGS WERE ASKED A VARIETY OF QUESTIONS INCLUDING DEGREE OF COMFORT IN WORKING WITH A NUMBER OF DIFFERENT POPULATIONS, PERCEIVED EFFECTIVENESS OF TREATMENT MODALITIES WITH THOSE GROUPS AND THE PRESENTATION OF THREE CASE STUDIES TO WHICH THE RESPONDENTS HAD TO INDICATE THEIR TREATMENT OF CHOICE.

THREE SURPRISING RESULTS EMERGED FROM THIS RESEARCH PROJECT:

1) IT WAS EXPECTED THAT MOST PEOPLE WOULD CHOOSE BEHAVIOR MODIFICATION AS THE PREFERRED TREATMENT WITH THE MENTALLY RETARDED. TO MY SURPRISE, THIS DID NOT HAPPEN! WHEN PRESENTED WITH THREE CASE STUDIES OF A MENTALLY RETARDED PERSON IN VARIOUS DEGREES OF DISTRESS, 58% OF THE RESPONDENTS CHOSE A PSYCHOTHERAPEUTIC APPROACH WHILE 36% CHOSE BEHAVIOR MODIFICATION WHEN THE DATA FROM ALL THREE CASES WAS COLLAPSED. THIS DEMONSTRATED THAT PEOPLE THOUGHT THAT PSYCHOTHERAPY CAN BE AN EFFECTIVE TREATMENT PROCEDURE WITH THE MENTALLY RETARDED.
2) HOWEVER, THE SECOND FINDING WAS WHEN WE LOOKED AT THE COMFORT FACTOR, 78% OF THE RESPONDENTS SAID THAT THEY WERE UNCOMFORTABLE IN WORKING WITH THE EMOTIONAL NEEDS OF THE MENTALLY RETARDED. THUS, PROFESSIONALS ARE SAYING THAT THEY ARE COMFORTABLE IN DOING PSYCHOTHERAPY OR BEHAVIOR MODIFICATION, BUT NOT WITH THE MENTALLY RETARDED. THEY ALSO FEEL THAT PSYCHOTHERAPY MAY BE AN EFFECTIVE INTERVENTION, FOR SOMEBODY ELSE TO DO.
3) THE LAST IMPORTANT FINDING WAS THAT THE RESPONDENT VIEWED BEHAVIOR MODIFICATION AND PSYCHOTHERAPY AS MUTUALLY EXCLUSIVE. THE NET RESULT OF

SUCH AN APPROACH WOULD BE TO NOT TREAT THE WHOLE INDIVIDUAL. THIS IS A SURPRISE SINCE THESE PROCEDURES CAN BE USED IN A COMPLIMENTARY FASHION RATHER THAN IN AN EXCLUSIONARY ONE.

CONCLUSION:

WHERE DOES THIS LEAVE US WITH REGARD TO "THE MISSING LINK" IN THE SERVICE NETWORK CHAIN? ONE FACTOR HAS BECOME VERY CLEAR. THAT IS, ALTHOUGH IT IS EXTREMELY IMPORTANT TO TEACH PEOPLE TECHNIQUES IN WORKING WITH THE EMOTIONAL NEEDS OF THE MENTALLY RETARDED, LACK OF KNOWLEDGE OF THESE TECHNIQUES IS NOT WHAT IS PREVENTING THE MENTAL HEALTH PROFESSIONAL FROM SEEING THE MENTALLY RETARDED IN PSYCHOTHERAPY. WHAT IS PREVENTING PROFESSIONALS FROM SEEING THE MENTALLY RETARDED IN THERAPY IS THEIR DISCOMFORT WITH THIS GROUP OF PEOPLE. THUS, A DESENSITATION PROGRAM FOR PROFESSIONALS SHOULD PRECEDE ANY TRAINING IN SPECIFIC THERAPEUTIC APPROACHES. PROFESSIONALS MUST BE COMFORTABLE WITH PEOPLE WITH MENTAL RETARDATION AS PEOPLE. THEN, AND ONLY THEN, WILLTHEY RECOGNIZE THE UNIQUENESS OF EACH INDIVIDUAL AND THE IMPORTANCE OF THEIR EMOTIONAL NEEDS.

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